IGO Infertility, Gynecology & Obstetrics
MEDICAL GROUP, AMC

Authorization to Release Protected Health Information

(HIPAA Compliant Request for Breast Imaging Records and Reports)

Be certain that information is accurate and complete. Incomplete authorizations are invalid.

Name of Patient	Street Address
Phone Number	City State ZIP Code
Maiden (or other) Name	Date of Birth XXX-XX- ___ ___ ___ ___ Social Security Number

I hereby give permission to release my Protected Health Information (PHI) also known as My Medical Records.

Please send My Records via Ambra or Nucleus to: UC San Diego Health Digital Library

OR

If this is not possible, please send by records to my address as indicated above.
I need all breast exams and reports on a CD DICOM format.

The Protected Health Information (PHI) I would like to have released is as follows:

☑ Release a copy of the previous 5 years records of breast imaging.

I am requesting my PHI to be disclosed for the following reason: __continuing medical care_____.

This authorization shall expire one year from the date of signature, or at the following event _____

I understand this information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule. I release you from all liability that may arise from your compliance with this request to release records.

I understand that this authorization will automatically expire one year from the date executed. I understand I may revoke this consent at any time in writing, except to the extent that action has already been taken.

I understand that I have a right to receive a copy of this authorization upon my request.

Patient Signature	Date
Witness Signature	Date